NSPCC Repository – October 2018

In October 2018 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Bolton LSCB: Baby D

Death of an infant under 3 months in December 2016. Baby D lived with his mother and older sibling. Father had lived in the family home but was deported from the UK before Baby D was born.

Mother started a new relationship with a man a few weeks prior to Baby D's death; both were in the home on the day of his death. The ambulance service received a call from the mother saying that she had found Baby D 'not breathing'. A post mortem concluded that Baby D had injuries consistent with death resulting from co-sleeping. After a police investigation into the death the Crown Prosecution Service advised there was no criminal case to pursue.

Learning includes: NICE guidance in relation to management of mental health issues in pregnancy should be followed by practitioners in all settings; professionals require ongoing training in relation to the effects and impact of cannabis on mental health and parenting; professionals need support in making enquiries about existing and new relationships; professionals should have access to support to address any concerns regarding resistant parents and unwillingness to change risk behaviours.

Recommendations include: ensure that GPs receive advice in relation to specific concerns regarding safe sleeping and that they take opportunities to reinforce safe sleeping advice; all relevant practitioners should have access to good quality drug and alcohol training and be aware of the services provided by local drug and alcohol services.

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Lincolnshire LSCB: Child F

Death of a 15-week-old boy after feeding from a propped-up bottle sitting in a car seat in October 2015. Cause of death was unascertained. Mother (Child MF) was 15 years old when Child F was born. There was uncertainty as to who the father was.

Child MF suffered from back pain, dizziness and lethargy when the baby was about 3 months old; she was struggling to cope with Child F and relied on her family for support. An adult was caring for Child F when he died. A post mortem discovered fractures to both legs which were non-accidental and occurred between 3 and 6 days before death. No person was identified as responsible for the injuries as it was impossible to conclude who was the carer at the time of the injuries.

Key learning includes: recognition of underage sex; where the mother is a child, both her and the baby need to be treated as such; the quality of the Child in Need procedure and meetings needs improvement; professional curiosity was lacking and over optimism took place.

Recommendations include: to ensure that the LSCB's Child in Need process is operating effectively; to ensure that all agencies working with a child or family record full details of all adults within the household; carry out and complete appropriate and relevant CSE risk assessments; highlight the importance of record keeping; professionals need to be able to recognise disguised compliance and dis-engagements; professional curiosity and healthy scepticism should be included in all levels of safeguarding.

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Oldham LSCB: Child G

Inflicted abdominal trauma to a 6-year-old child, in June 2014 while in the care of mother's partner. Child G lived with their mother, her partner and younger half-sibling, while two maternal half-siblings lived with a family member following a series of safeguarding concerns prior to the birth of Child G.

In 2012, mother of Child G was allocated a home in Oldham, to assist in moving from an abusive relationship. Over the following ten months, Child G's school made referrals to children's social care, resulting in an initial assessment.

In June 2014, Child G presented unwell at school and was taken home. After a serious episode of vomiting, Child G was taken to the GP and then to the regional children's hospital by ambulance. Doctors concluded Child G had been subject to inflicted abdominal trauma, and referred the findings to children's social care. Child G and their half-sibling were placed in foster care. Child G later disclosed that their mother's partner had caused the abdominal injuries in June 2014. Mother's partner charged with assault of Child G and faces criminal trial.

Findings include: professionals engaged in multi-agency working must be attuned to non-verbal methods of communication and advocate for a child that is not being heard.

Recommendations include: LCSBs must ensure GPs are part of multi-agency safeguarding arrangements; and working directly with men in families must be embedded in professional thinking. Please note that this report was written in July 2016 but was published in February 2018.

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Oldham LSCB: Baby H

Injury of an 11-week-old boy in September 2014 as a result of non-accidental head injury due to shaking. Baby H and twin sibling were born 10 weeks prematurely and kept in neonatal care for almost seven weeks, then discharged into parental care.

Four weeks later Baby H was admitted to A&E with head injuries, following a 999 call from Baby H's Aunt. Children's Social Care had been involved with family previously over concerns about the neglect of three older siblings, who were later removed from mothers care. Mother was charged with neglect and father charged with neglect and Section 18 wounding. Criminal proceedings were still underway at the time of writing.

Learning includes: improved understanding by Neonatal staff about the triggers which can lead to abusive head trauma in young babies would be beneficial; help with the support and guidance that Neonatal staff offer to all parents, particularly those whose babies may be considered vulnerable; lack of professional awareness of specific details of pre-birth Assessment Procedures and consequently potential risks; during organisational change local authorities need to be aware of the risks that transitions pose to safeguarding practices.

Recommendations include: criteria and procedures for starting pre-discharge meetings should be robust and understood by all professionals involved; consideration should be made to co-operating with other LSCBs to explore how learning can be shared to develop policy and practice. Please note that this report was written in June 2016 but was published in 2018.

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Unnamed LSCB: Child M and Child L

Severe neglect of twins aged 22-months in June 2016. Mother had three children removed from her care in March 2005 due to neglect and emotional abuse. Twins were born prematurely in 2014 and required treatment at several hospitals. On discharge, the twins were made subject to a child in need plan for six months but this was closed after three months.

A health visitor supported the mother and twins with community services. A referral in May 2016 from the housing department to Children's Services identified child protection and welfare concerns for the children. A month later they were taken to hospital where a paediatrician confirmed they were suffering from extreme neglect. The mother was arrested for cruelty and neglect; the police decided not to take further action following completion of their investigation.

Findings include: the need to remind key practitioners of national and local safeguarding policies and procedures; identification of concerns as to the function of the governance and supervision of child protection cases; the need to remind police investigating officers of agreed guidance on sharing information in parallel processes involving criminal proceedings and SCRs; the need to review case allocations and ensure that key practitioners have the necessary experience and supervision.

Recommendations include: to remind all staff of the need to have knowledge and awareness of learning from SCRs when carrying out their child protection roles; to ensure there is compliance in place, for all staff, when there is a conflict of interest; to ensure record keeping is enhanced and expeditiously recorded onto the computer management system.

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Unnamed LSCB: Child S

Non-accidental injuries to a 13-week-old infant in December 2015, including fractures to the skull, ribs, legs and elbow. During her pregnancy, mother suffered the sudden death of her paternal grandmother closely followed by the death of her father. Child S's birth was followed by complications which separated mother and child overnight.

A bite mark and bruising was noticed on three occasions by different health professionals, the first injury when Child S was ten days old. Child S was taken to A&E by both parents following an injury to the head. A number of other injuries were subsequently discovered. Child S was taken into foster care and the parents arrested and charged. The mother admitted to causing the fractures, the father admitted to causing a bite mark and bruising when winding the baby.

Key findings include: lack of adherence to child protection procedures regarding when to make a referral to children's social care; perception of the family's background and culture on professionals failed to challenge the picture presented and think the unthinkable.

Recommendations include: GPs to be reminded of the importance of observing babies and documenting their interactions; the LSCB should review and ensure compliance with child protection procedures in respect of bruising to non-mobile babies including clear guidance and training; the full Edinburgh Postnatal Depression Scale screening should be undertaken where there are clear risk factors identifiable during pregnancy; all community midwives to be aware when any type of injury is seen, it should be escalated to the Maternity Safeguarding Team.

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